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ABSTRACT

Hypotheses presented in an initial report of this study were tested and, in general, all were supported. Maternal diagnosis, chronicity, and age of onset with regard to the child and to parent/child interaction were significantly associated with child competence. However, effects of these factors were not consistent across age of child or child environment. Affective diagnosis and chronicity of emotional illness were found to have strong associations with competence. When school competence ratings were used to define high versus low competence, affective diagnoses of mothers hospitalized for psychiatric disorders appeared to have a great effect on older children (10 years old), while chronicity of mothers' emotional illness more highly affected younger children (7 years old). When parent ratings were used to define high versus low functioning, affective diagnoses of mothers were significantly related to competence of children at both ages, while chronicity of illness again was related to competence only in the younger group. Indexes of balance and warmth of parent/child interactions were significantly related to child competence when defined by school ratings, but not when defined by parent ratings. Data are discussed in relationship to the need for multiple indexes of competence and with respect to the requirements of children at risk in different age groups. Also, suggestions are offered regarding the compensatory effect of the nondisturbed parent through the influence of an affective family interaction construct. (Author/RH)

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COMPETENT CHILDREN AT RISK: THEIR PARENTS AND FAMILIES:

2. MARKERS OF COMPETENT CHILDREN

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Our analyses partially supported Hypothesis I suggesting a positive relationship between school rated child competence and affective diagnosis of the patient/parent (cf. table 2). Boys in the more competent group were significantly more likely to have a parent who had an affective diagnosis, i.e., major bipolar, depressive or schizoaffective disorders (83%) than boys in the less competent group (53%, $X^2 = 4.74$, $p < .05$). When controlled for age, this effect held its significance only for 10 year old boys (cf. table 3) where 88%

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of the parents in the high competent group were labeled affectively disordered while only 27% had such labels in the low competence group (X^2 = 10.14, $p < .01$). If mothers of the children in these extreme groups had non-affective diagnoses, their diagnoses were either personality disorders, moderate or severe, or schizophrenia and these mothers tended to have children who displayed low competence in school.

For Hypotheses II, boys who were rated less competent also had mothers with high chronicity ratings while boys who were rated more competent had parents with lower chronicity ratings (t = 3.35, $p < .001$ (Table 4). When controlled for age, the significant effect held only for the 7 year old group ($\bar{X}$ = 4.82 for the high competence group and $\bar{X}$ = 3.50 for the low competence group). Inspection of the interaction of parental affective diagnosis with chronicity of parental illness showed that parents of more competent children with affective diagnoses had lower chronicity ratings while parents of less competent children with affective diagnoses tended to have high chronicity ratings. This relationship did not hold for schizophrenic and personality disorder diagnoses which were associated with high chronicity of parent/illness no matter which group the boys were in. Therefore, affective diagnoses and low chronicity appeared to be associated with high school competence in offspring.

When parent ratings of competence derived from the Rochester Adaptive Behavior Inventory were used to divide the sample into competent or less competent groups, the results were essentially the same. Eighty-eight percent of the patient mothers of the high competent boys had affective diagnoses compared to 54% of the mothers

of the low competent boys. This difference held across both 7 and 10 year old groups. Ratings of chronicity of illness were negatively related to child competence, i.e., mothers of the boys having higher competence ratings had significantly lower levels of chronicity ($\bar{X}$ = 4.69). When controlled for age the effects of chronicity held again only for the 7 year old group with mothers of the higher competence boys having lower chronicity of illness ratings ($\bar{X}$ = 3.9) compared to mothers of the lower competence boys ($\bar{X}$ = 5.33). Greater impact is given to this significance by the fact that school ratings correlate at nonsignificant levels with parent ratings. Obviously, the relationships of school and parent rated competence to maternal diagnosis and chronicity of mothers' illness are based on different parts of the variance of these two variables.

Following Hypothesis III, the more competent and less competent groups were then compared on the 3 Balwin/Cole family interaction variables, i.e., mother to child, father to child, and both parents to child (Tables 5-7). When the comparisons were based on school ratings of competence, significant positive findings occurred for the 10 year old boys but not for the 7 year old boys. For the 10 year old boys, significance was reached for all three measures: both parents to child (t = 12.23, p .001) father to child (t = 8.43, p .01), and mother to child (t = 3.7,p .07), although marginally. These findings suggest that a child's school competence is related to a warm and balanced relationship with his parents when his mother has had a significant mental illness.

When similar analyses were repeated using the extreme groups based

on parent ratings from the Rochester Adaptive Behavior Inventory, none of the above relationships were found and, surprisingly, none of the relationships even approached significance. How parents rated their sons competence was not related to the balance and warmth of their relationship with him. The consistency of relationship between both maternal diagnosis and chronicity and both school and parental measures of child competence argues for the significance of these 2 adult stress related variables to child health and development.

Regarding Hypothesis IV., research has consistently demonstrated that exposure to stress and parenting at early stages of a child's life are related to greater difficulties at later critical developmental stages leading to a greater susceptibility to disease and mental illness. With this in mind, it appeared reasonable to assume that the older a child is when exposed to his parent's illness, and the shorter the period of time of this exposure, the greater chance he will have of managing the potential crisis effectively and behaving competently. Therefore, we selected subsamples of competent and incompetent boys whose mothers' illnesses first occurred prior to their first birthday. Comparisons between these two groups indicated that the time in a child's life when a chronically ill mother's first significant illness occurred was significant but only for the 7 year old boys (Table 8). Among 7 year olds, boys were given lower competence rings if the first episode of their mother's illness occurred prior to their first birthday. If it happened after their first birthday, they tended to be rated higher in competence. Among the 10 year old children of chronically ill mothers there appears

to be no effect on ratings of child competence due to when in the child's life his mother's first episode of illness occurred.

When the same analysis was repeated using mothers who were not chronically ill, no differences were found in the extreme groups analysis. It did not appear to make a difference when the mother's illness first occurred in the child's life if mother was not chronically ill.

The findings from the mother's chronicity of illness by age of child at onset may be due to two affects. On the one hand, the 7 year old children rated low due to a mother's chronic illness which occurred early in their lives are still too young to have realized other supports. However, by age 10 they have reached a developmental stage where they may take advantage of alternative support groups to assist in their emotional and social development. On the other hand, the 7 year olds who have experienced their mothers' chronic illness later in life are rated high due to less experience with an ill mother. By age 10 the effects of the chronically ill mother begin to impact on their functioning so they appear to be less competent.

DISCUSSION: In general, all 5 hypotheses were supported. Maternal diagnosis, chronicity, age of onset vis-a-vis the child and parent-child interaction were significantly associated with child competence. However, their effects were not consistent across age of child or child environment. Affective diagnosis and chronicity of

emotional illness were found to have strong associations with the competence of the URCAFS children in their middle childhood years. When using the school competence ratings to define high versus low competence boys, affective diagnoses of mother/patients appeared to have a great effect at the older ages (10 years old) while chronicity of mother's emotional illness was more highly related at the younger ages (7 years old). When using parent ratings to define high versus low functioning, affective diagnosis was significantly related to competence at both ages while chronicity of illness again was related to competence only in the younger ages (7 years old). Indices of balance and warmth of parent/child interactions were significantly related to child competence when defined by school ratings but not when defined by parent ratings.

These findings are concrete illustrations of Anthony's (1974) and of Fisher and Kokes' (1982) observations regarding competent children at risk. First, children are not competent across all dimensions or even along individual, social, cognitive, or behavioral dimensions across all ages. Growth is remarkably variant with alterations in competence by area and age. Therefore, the use of a summary score based on multiple indices will not reflect the complexities and variations of growth and development. Further, overall growth and development occurs at different rates at different stages so that children who appear more competent at early stages of development may show negative outcomes at later stages. These developmental patterns are potentiated or attenuated by the emergence of buffering, damaging, and or enhancing conditions or agents into the child's life at critical

stages. For example, in our cross sectional analyses, chronicity of mother's illness seems to have had a less deleterious effect on the children at 7 and at 10. It would appear possible that as children grow older and move into the exra-familial social environment of school and peer systems they gain social supports that might replace the positive social support expected but not received from parents. In the case of sons of mother/patients, the effects of a positive social relationship with a competent father also might ameliorate the effects of the ill mother. From the analyses in this paper and others we have in process, there are suggestions that such a compensatory effect may be operational. One well parent with a balanced emotional relationship with the child may supply the resources necessary for successful development even in a family environment which includes a chronically ill, emotionally unavailable parent.

The confluence of the significant relationships between maternal and family variables to child competence provides some support for the notion of an underlying affective family interaction construct intrinsic to successful child development. Implied in such a construct is the necessity of exchange of both positive and negative affect among family members to allow for the free exploration of needs, drives, and motivations by the child. Parental affective disorder at least implies the parent's ability to engage in an emotional interchange thus providing the impetus for affective interchange between parent and child, even when some of these interchanges may be nonproductive. In addition, balanced and warm interactions between parent and child provides the secure environment for exploration, discussion and

discovery of the self.

Finally, it is important to note that parental ratings of child competence did not correlate with school ratings of child competence. One potential explanation is that school ratings reflect child behavior more objectively because children produce concrete products on which they are graded while home ratings are more subjective and dependent on and reflective of personal characteristics of the parents. In support of this notion we found school competence ratings significantly related both to parent characteristics and to observers ratings of family behavior while parent rated competence was related only to parent characteristics of diagnosis and chronicity of illness. Analyses presently under way will investigate whether or not maternal ratings of child behavior are strongly influenced by material disorder such that these ratings are not clearly reflective of their offspring's functioning.

UNIVERSITY OF ROCHESTER

CHILD AND FAMILY STUDY

TABLE 1

DISTRIBUTION OF PATIENT/PARENTS BY DIAGNOSIS

(N=145)

DIAGNOSIS	N	%
Schizophrenia	18	12
Bi-polar Affective Psychosis	27	19
Major Depressive Psychosis	11	8
Schizoaffective Disorder	11	8
Major Depressive Disorder, Non-psychotic	31	21
Personality Disorder, Severe	12	9
Personality Disorder, Moderate	19	13
Bipolar Affective Disorder, Non-psychot.	8	5
Anxiety Disorder	8	5

TABLE 2

AFFECTIVE DIAGNOSIS X COMPETENCE OF 7 AND 10 YEAR OLD BOYS

TEACHER-PEER COMPETENCE RATING	DIAGNOSIS	
	AFFECTIVE	NON-AFFECTIVE
HIGH	20	4
LOW	10	9

$X^2 = 4.74$, $p < .05$

TABLE 3

AFFECTIVE DIAGNOSIS X COMPETENCE X AGE OF BOYS

TEACHER-PEER COMPETENCE RATINGS	7 YEAR OLDS		10 YEAR OLDS	
	DIAGNOSIS		DIAGNOSIS	
	AFFECTIVE	NON-AFFECTIVE	AFFECTIVE	NON-AFFECTIVE
HIGH	6	2	14	2
LOW	7	4	3	8
	n.s.		$X^2 = 10.14$, p	.0

TABLE 4

CHRONICITY OF PARENT ILLNESS X CHILD COMPETENCE X AGE OF BOYS

TEACHER-PEER COMPETENCE RATINGS	7 YEAR OLDS	10 YEAR OLDS	7 + 10 YEAR OLDS
HIGH	3.50	3.56	3.54
LOW	4.82	4.38	4.63
	(t = 4.80, p .001)	n.s.	(t = 3.35, p .001

TABLE 5

MOTHER/CHILD INTERACTION X CHILD COMPETENCE X AGE OF BOYS

TEACHER-PEER COMPETENCE RATINGS	7 YEAR OLDS	10 YEAR OLDS	7 + 10 YEAR OLDS
HIGH	.33	.69	.56
LOW	.25	.33	.29
	n.s.	(t = 3.7, p .07)	

TABLE 6

FATHER/CHILD INTERACTION X CHILD COMPETENCE X AGE OF BOYS

TEACHER-PEER COMPETENCE RATINGS	7 YEAR OLDS	10 YEAR OLDS	7 + 10 YEAR OLDS
HIGH	.25	.08	.17
LOW	.56	.56	.56
		(t = 8.43, p .01)	

TABLE 7

PARENT/CHILD INTERACTION X CHILD COMPETENCE X AGE OF BOYS

TEACHER-PEER COMPETENCE RATINGS	7 YEAR OLDS	10 YEAR OLDS	7 + 10 YEAR OLDS
HIGH	.50	.42	.46
LOW	.89	1.25 (t = 15.6, p .001)	1.12 (t = 12.2, p = .001)

TABLE 8

OFFSPRING COMPETENCE OF MOTHERS WITH

EARLY VERSUS LATE ONSET OF DISORDER

	7 year old sons		10 year old sons	
	Low Competence	High Competence	Low Competence	High Competence
Early Onset 1 year old	7	1	4	4
Late Onset 1 year old	2	8	2	4

$X = 8.1$, $p < .01$ n.s

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ABSTRACT

Each of the hypotheses presented in the first paper were tested and, in general, all were supported. Maternal diagnosis, chroncity, age of onset vis-avis the child and parent-child interaction were significantly associated with child competence. However, their effects were not consistent across age of child or child evironment. Affective diagnosis and chroncity of emotional illness were found to have strong associations with competence. When using the school competence ratings to define high versus low competence, affective diagnoses of mother patients appeared to have a great effect at older ages (10 years old) while chroncity of mothers' emotional illness was more highly related at the younger ages (7 years old). When using parent ratings to define high versus low functioning, affective diagnosis was significantly related to competence at both ages while chroncity of illness again was related to competence only in the younger ages. Indexes of balance and warmth of parent/child interactions were significantly related to child competence when defined by school ratings but not when defined by parent ratings. Discussion of these data in relation to the need for multiple indexes of competence and for children at risk of different age groups is presented. Also, suggestions regarding the compensatory affect of the non-disturbed parent through the influence of an affective family interaction construct are presented.